**Reviewer’s report**

**Title:** Clinical Features of Delirious Mania: A Series of Five Cases and Brief Literature Review

**Version:** 2 **Date:** 23 July 2011

**Reviewer:** Max Fink

**Reviewer’s report:**

July 22, 2011

Clinical Features of Delirious Mania: A Series of Five Cases and Brief Literature Review  
Bo-Shyan Lee, Si-Sheng Huang and Nan-Ying Chiu  
BMC Psychiatry  
Research article

Summary: In a chart review of hospitalized patients with a history of bipolar disorder the authors sought cases of acute delirium; they identify 5 records from a 2-year sample. All were treated with polypharmacy and two with ECT.

The authors undertook the study to better define "delirious mania" (DM), a condition not sanctioned by DSM criteria. In a literature review they identified 15 other cases. (Query 1) and compared the findings to their own. They also sought to answer the suggestion by Fink (1999), Fink & Taylor (2003) and Taylor and Fink (2003) that DM is a syndrome more closely associated with malignant catatonia (MC) than with bipolar disorder (BPD). As they examined only charts of patients with a history of BPD, and no formal tests of catatonia were done, they cannot contribute to this argument.

As the patients were treated without a specific protocol for ECT or for medications, they report the impact of unspecified polypharmacy. The report also fails to contribute to the role of ECT in DM.

The authors focus interest on the study by Karmacharya et al (2008) -- a chart review for patients with mania and delirium reporting the records of 16 cases. Like the present study, this chart review does not contribute to the questions of the role of BPD in DM nor the efficacy of ECT nor the question whether DM is best viewed as a form of BPD or as a type of catatonia.

DM is tied to BPD by expectation (that delirious mania must be a form of mania which must be a form of BPD) and by the limitation in the psychiatric classification that reifies BPD as a distinct entity. By assuming that delirious mania is a type of BPD the reviewers ignore the many cases of DM associated with systemic diseases (e.g., lupus, infections, intoxications).
Queries: (1) The number of cases in their literature review fluctuates. Please specify the sources of the numbers.

Critique: The report is an interesting reminder that DM is a recognizable entity and that ECT is its effective treatment. By restricting their sample to patients with a history of BPD the study does not contribute to the arguments that:

a. DM is an acute syndrome not necessarily associated with BPD;
b. That ECT is the effective treatment for DM;
c. That DM is better associated with catatonia, a definable motor dysregulation syndrome not part of schizophrenia, than with MDD.

The tables are overwhelming and should be replaced by adding more detail to the case reports.

Errors: In introduction, the reference is to Bell, not Beck. References 18 and 21 are to the same report.

Recommendations: Acceptable for publication as a reminder of an interesting and understudied acute psychiatric syndrome, that has been documented for two centuries. The discussion of the literature can be better summarized by noting that the cases before 1980 were not tied to BPD.

The report is a basis for a prospective study of admissions of patients with delirium, examination for medical reasons, and further study of the non-medical cases for catatonia, for history of bipolar disorder in patient and family; and for a restricted treatment protocol that focuses on a specific Rx for BPD (Lithium, anticonvulsant and/or atypical neuroleptic) or catatonia (BZD or ECT). The review justifies such a prospective study.

References.
Fink 1999: Authors reference 8

Additional note.
A short chapter in a forthcoming Biography of Catatonia (in preparation) discusses the present position of DM in relation to psychiatric classification. Below is the section on DM that may interest the authors.

For more than two centuries, clinicians have described the acute onset of agitated and excited dreamy or delirious states, often so severe as to result in death. In a 13-year chart review of 1700 admissions to the McLean Hospital in Boston, Bell (1849) described 40 patients with acute onset of delirium, fever, and uncontrollable excitement (sometimes alternating with stupor), of whom three-quarters died. Similar descriptions by Calmeil (1859), Stauder (1934), Arnold (1949), Taylor and Abrams (1973), Bond (1980), and Fink (1999) confirm
the characteristics of the syndrome.

The principal feature of delirious mania is a nightmarish, dreamlike derealization within an altered sensorium. The change in perception is profound, frightening the subject and leading to paranoid thoughts and restlessness. Patients thrash about harming themselves and others. Stereotypy, grimacing, posturing, echolalia, and echopraxia are frequent. Negativism and automatic obedience are almost always present. Patients sleep poorly, are unable to recall their recent experiences, or the names of objects or numbers given to them. They are disoriented and confabulate, often telling fantastic stories. The onset develops rapidly, within a few hours or a few days. Fever, rapid heart rate, elevated blood pressure, and rapid breathing are prominent. Patients hide in small spaces, close the doors and blinds on windows, and remove their clothes and run nude from their home. Garrulousness, flights of ideas, and rambling speech alternate with mutism.

The acute onset leads clinicians to search for a toxic or infectious cause or a seizure disorder. When speech becomes incomprehensible, schizophrenia is considered. When grandiosity and delusional ideation dominate the picture, mania is more easily recognized. When delirium is the main feature, a full neurologic evaluation, including extensive brain imaging procedures, is usually done. Regardless of presumed cause, the presence of severe mania and delirium, with or without catatonia, justifies the syndromal diagnosis of delirious mania.

Until recent times patients were sedated with opioids, chloral hydrate, and alcohol. Chlorpromazine combined or followed with lithium is occasionally effective. But ECT is the most effective treatment. It resolves excitement (or stupor) with a few treatments, especially if the treatments are administered daily. A review of the literature and description of successful treatments with ECT strengthens the position that delirious mania is a treatable syndrome. A sad consequence of the widespread limited availability of ECT is that patients are now commonly sedated with haloperidol. In their state of dehydration and autonomic instability an acute neurotoxic syndrome often ensues with fatal results.

In the French literature the syndrome is occasionally described as onirisme and the translated terms oneiroid state or syndrome or oneirophrenia are favored by some authors for the dreamy, stuporous state. In a small text Meduna described oneirophrenia in sufficient detail to identify the signs of catatonia. He distinguished the syndrome from schizophrenia, believed that it was a manifestation of abnormal glucose metabolism, and reported 64% full remission with ECT.

The pathophysiology of delirious mania is unknown. The connection to bipolar disorder or manic-depressive illness is inferred and only occasionally confirmed by the patient's history. More often the patient's history has no psychiatric antecedents. Is the syndrome rooted in delirium? From time to time an acute delirium, whether of a toxic or post-traumatic nature, has been treated
successfully with ECT. Considering delirious mania as a form of catatonia rather than to bipolar disorder offers a bridge to effective relief.

Max Fink, M.D.
Stony Brook University
Long Island, New York

**Level of interest:** An article of limited interest

**Quality of written English:** Acceptable

**Statistical review:** No, the manuscript does not need to be seen by a statistician.

**Declaration of competing interests:**

I declare that I have no competing interests.